MISSOURI COMMISSION ON PATIENT SAFETY
MEETING MINUTES
May 27, 2004
10:00 a.m. – 2:30 p.m.
Via conference call

OFFICIAL

Commissioners in attendance: Gregg Laiben, MD, Kathryn Nelson, Thomas Cartmell, Deborah Ann Jantsch, MD, Susan Kendig, Alan Morris, MD, Bea Roam, William Schoenhard, James Utley, MD, Kenneth Vuylsteke, Kevin Kinkade, Lori Scheidt, Scott Lakin (Any person on the call for some period of time was considered in attendance. Not all of the above were able to stay on the call for the entire time)

I. CALL TO ORDER
Dr. Gregg Laiben, Chairperson
The meeting was called to order at 10:05 AM. Roll call was taken aloud.

Housekeeping items:

Linda announced the agenda would be review of several housekeeping items, including the minutes from the previous meeting, and the remainder of the meeting would be spent discussing the draft recommendations and glossary.

Linda Bohrer announced that the corrections to the executive order have been finalized. Also, the letter to appoint Lois Kollmeyer as Dick Dunn's representative will be sent to the Governor.

Dr. Laiben and Randy McConnell briefly reviewed the procedure for the presentation to the Governor. The presentation will occur at the Capital in the Governor's second floor office. The press will be invited. There may be an opportunity for the Chairs to say a few brief words, but the presentation itself should not take very long. The Governor is planning on eating lunch with the Commission.

Dr. Morris asked when the draft Executive Summary would be sent for the Commissioners to read and comment on. **It was agreed that this would be sent to all Commissioners no later than June 10, a week before the next conference call. All comments must be sent back to Linda Bohrer by June 14 (Monday), no later than 5 PM. Commissioners are asked to utilize the "reply to all" feature in emailing back to Linda, so that everyone can see everyone else's comments.** Linda will incorporate comments, or show optional edits if necessary, for the Commissioners to agree to during the next conference call. The Executive Summary (with comments), the Recommendations and the body of the report will be emailed to all Commissioners by June 16 at 5 PM.

Review of Draft Minutes from the previous meeting

Dr. Laiben noted that "roll" should be changed to "role" throughout the draft minutes. Dr. Morris asked about two items in the minutes that he couldn't find in the latest draft recommendations. Those items were located. There were no further corrections noted for the previous draft meeting minutes. Dr. Morris moved to accept. Dr. Utley seconded. The minutes were approved on a voice vote and there were no objections.

II. WORKING MEETING

Dr. Laiben noted that all the draft recommendations needed to be discussed and agreed to today.

Recommendation #1: All Missouri organizations providing healthcare services should adopt minimum procedures (standards) for improving the safety of their patients.

Dr. Laiben didn't care for the use of "minimum standard". He expressed concern that some entities would adopt the minimum standards and go no further. Dr. Utley agreed, and added that a nuance has been lost. Many organizations have never heard of patient safety, and half the battle will be simply to raise their awareness of the issue. Several Commissioners agreed with this point. It was agreed to revise the main recommendation as follows: **All Missouri healthcare organizations and professionals should be educated regarding patient safety, and encouraged to adopt protocols and processes for improving the safety of patients.**

Recommendation #1a: Establish a procedure for disclosing errors to patients, their families or guardians.

Kathryn Nelson felt the list of sub-points needed to be prefaced in a manner that would tell readers that the sub-points are the "protocols and processes" health care providers should adopt. Dr. Utley agreed, noting that otherwise, the sub-points sound optional. Disclosure to patients, for example, should not be perceived as optional. Generally the Commissioners agreed with this sentiment. It was agreed that a statement before the sub-points would read: "**Protocols and processes should include:**".

Dr. Laiben expressed concern with use of the term "medical error". His colleagues were sensitive to this term. **It was agreed to use "adverse event or adverse outcome" instead of "error" throughout the recommendations, unless context indicated otherwise. Both those terms are to be defined in the glossary.**

William Schoenhard asked if "standard" could be used instead of "procedure". Dr. Laiben objected to the term "standard". Kathryn Nelson asked if the active verb "disclose" should start the sentence. Scott Lakin countered that a written document helps ensure that all patients are treated the same. He suggested "guidelines"

instead of "standard" or "procedure". After discussion of various options, it was agreed to revise #1a as follows: "**Establish guidelines for disclosing adverse events and adverse outcomes to patients, their families or guardians.**"

Recommendation #1b: Provide a resource for counseling to anyone physically or emotionally impacted by the error.

Kathryn Nelson expressed minor concern with the counseling piece. Not all providers would be able to provide counseling. Sue Kendig felt the language was not requiring the provider do the counseling, as long as an option was made available that people could take advantage of if they chose. Kathryn concurred.

Dr. Laiben noted that "error" would be replaced as discussed earlier.

Subsequent discussion of #1g and #6c lead to the agreement that #1b would be revised as follows: "**Provide an identifiable resource for information, counseling and advocacy to anyone physically or emotionally impacted by adverse events.**"

Kathryn Nelson asked if the order of the sub-points was deliberate or not. Linda Bohrer noted that 1a and 1b were, in her understanding, meant to go first and to go together. Otherwise no particular order was intended. It was agreed that each sub-point would be discussed, and after all were agreed to, the Commission would look at the order of sub-points.

Recommendation #1c: Designate a "patient safety officer" with consideration given for the size of the healthcare organization (and the type of healthcare delivered).

Dr. Laiben felt the parenthetical phrase was not necessary. Kathryn Nelson asked if the language about "consideration for the size" was expressing the intent of the Commission correctly. Dr. Jantsch and Dr Laiben both noted that their perception from other physicians was that even small practices wanted to address patient safety. Dr. Utley made a suggestion that everyone was comfortable with. It was agreed that #1c would be revised as follows: "**Designate a patient safety officer appropriate to each individual healthcare setting.**" This language captures both size and type as facets that demand flexibility in how this recommendation is carried out.

Recommendation #1d: Create a "culture of safety" with an emphasis on correcting systemic failures that jeopardize patient health (while still providing for necessary accountability).

Dr. Laiben felt the parenthetical phrase was not necessary. Kathryn Nelson read alternative language she had drafted. Everyone liked her proposed alternative. Linda Bohrer noted that there is no definition of "culture of safety" in the glossary, and asked if there should be one. Dr. Utley felt this term didn't need to be in

quotations. Dr. Morris felt a definition was necessary. Kathryn Nelson suggested a national definition could be used. Linda Bohrer said the term could be defined in the text of the report. **It was agreed to handle this term in the text, using a national definition**. It was agreed to revise #1d as follows: "**Create a culture of safety by focusing on system improvements and process changes.**"

Recommendation #1e: Establish internal patient safety reporting systems for adverse events and near-misses (without fear of reprisal).

Dr. Laiben didn't think it was necessary to mention near-misses. Kathryn Nelson disagreed, but suggested the parenthetical was unnecessary. William Schoenhard agreed. **It was agreed that the parenthetical would come out, but otherwise no changes were needed to #1e.**

Recommendation #1f: Establish a system to monitor "best practices."

Dr. Morris noted that there is no definition of "best practices". If JCAHO's best practices are intended, he suggested revising 1f, including emphasis on using best practices. Lois Kollmeyer countered that the Commission should not be seen as promoting some organizations but not others. Other Commissioners did not want to detract from recommendations that might come from the state "Center". After discussing various options, it was agreed 1f should be revised as follows: "**Develop an awareness of best practices and implement as appropriate.**"

Kathryn Nelson noted that tools such as root cause analysis and failure modes and effects analysis were not mentioned in the recommendation, and felt they should be. The Commissioners agreed. Dr. Laiben felt there wasn't time to draft a whole new sub-point. He **asked Kathryn to draft something on her own, and asked Commissioners if they would agree to whatever she drafted. The Commissioners agreed to do this.**

Recommendation #1g: Provide a resource for trained advocates to provide information to patients and their families during and after medical errors.

It was noted that "medical errors" would be replaced as discussed earlier.

Dr. Laiben asked how 1g is different from 1b. Linda stated that 1b dealt with professional counseling to help cope with the effects, if any, of an adverse event. 1g refers to a person that helps patients and families navigate the healthcare system. Kathryn Nelson concurred, and noted that the recommendation comes from a national organization. The intent is to get patient representatives at institutions involved with and knowledgeable about patient safety. **It was agreed to delete 1g as a free-standing sub-point, but to incorporate this item into 1b.**

Recommendation #1h: Provide protection to any healthcare professional or employee who in good faith reports conditions or events that jeopardize patient safety.

Dr. Laiben noted that this item is essentially repeated at 3g. Dr. Utley felt "provide protection" was ambiguous. Alternate language at 3g makes it clear that specific settings are in mind. **It was agreed that 1h could stay as it is, but that the alternate language provided at 3g would be used, so that a more specific statement follows a general statement.**

Recommendation #1i: Establish a procedure for ongoing review of adequate availability of healthcare professionals and staff training (thereby recognizing the role of these components in promoting patient safety).

The only comment was to take the parenthetical marks out, and keep the language about patient safety.

Recommendation #1j: Establish a procedure that recognizes the need for ongoing evaluation of technological advances that can enhance patient safety.

There were no suggested changes for this item.

Recommendation #2: Missouri should establish a "Patient Safety Support Center" to provide assistance for patient safety activities to healthcare organizations and healthcare professionals, as well as provide leadership and educational opportunities on patient safety, spanning a broad spectrum of health care. The "Support Center" should be a private (not-for-profit) organization, partnering with appropriate state agencies.

Kathryn Nelson felt it was too wordy and read suggested changes. It was agreed to revise #2 as follows: "**Missouri should establish a "Patient Safety Support Center" as the leadership vehicle for future unified coordinated patient safety improvement. The "Support Center" should be a private organization, partnering with appropriate state agencies.**"

Recommendation #2a: Become a clearinghouse for collection, analysis, and dissemination of information and tools related to the issue of patient safety.

There were no comments or suggested changes for this item.

Recommendation #2b: Collect information on and recommend "best practices" that eliminate conditions contributing to medical errors and disseminate those findings broadly to healthcare organizations, healthcare professionals and consumers.

Dr. Jantsch was somewhat unhappy with "recommend". It was agreed to delete "and recommend". Kathryn Nelson noted that "medical errors" should be replaced as discussed above, but that it wasn't necessary to mention adverse outcomes. It was agreed that #2b would be revised as follows: "**Collect information on "best practices" that eliminate conditions contributing to <u>adverse events</u> and**

disseminate those findings broadly to healthcare organizations, healthcare professionals and consumers."

Recommendation #2c: Provide training and support for healthcare organizations to implement patient support groups and advocacy programs.

Sue Kendig asked to add healthcare professionals to the statement. It was agreed #2c would be revised as follows: "**Provide training and support for healthcare organizations and professionals to implement patient support groups and advocacy programs.**"

Kathryn Nelson felt it was important to mention technical assistance with root cause analysis and failure modes and effects analysis. Dr. Laiben agreed. **It was agreed Kathryn Nelson would work with Linda Bohrer to draft an additional sub-point.**

Recommendation #2d: Adopt a common lexicon of terminology to be used in relation to patient safety and error prevention.

There were no comments or suggestions for changes, **except to replace "error"** as discussed above.

Recommendation #2e: Establish an "education coalition" to develop a multidisciplinary curriculum for undergraduate, graduate and continuing education of healthcare professionals on patient safety.

There were no comments or suggestions for changes, **except to replace "error"** as discussed above.

Recommendation #2f: Collect, develop, and disseminate materials for healthcare consumers that help them make safer choices in their healthcare and course of treatment.

There were no comments or suggestions for changes.

Recommendation #2g: Provide a setting for Missouri citizens, who are leaders in the area of patient safety, to work together to advance patient safety (activities and initiatives).

Dr. Laiben suggested the optional language in parentheses was good, and should be included. Everyone agreed. There were no additional comments or changes on this item.

Recommendation #2h: Work with the federal government and state, regulatory agencies, JCAHO (Joint Commission on the Accreditation of Healthcare Organizations), and other organizations widely involved with patient safety reporting to eliminate duplicate reporting, determine what information should be

reported and to whom, and in what format the information should be reported (, develop a standardized format for reporting), including reporting of actions taken and solutions identified to address patient safety issues.

Dr. Laiben thought the optional language in parentheses should be deleted. Dr. Utley suggested additional edits to make the recommendation less wordy. Several other Commissioners suggested minor edits. It was agreed to revise #2h as follows: "**Work with the federal and state governments, regulatory agencies, JCAHO (Joint Commission on the Accreditation of Healthcare Organizations), and other organizations involved with patient safety reporting to eliminate duplication of activities.**"

Recommendation #2i: Analyze available data and make findings available on areas likely to compromise patient safety.

Dr. Laiben suggested removing the first "available". Kathryn Nelson asked if this one could come after #2j instead of before it. Everyone agreed to this. The recommendation will be **renumbered as #2j** and will read: "**Analyze data and make findings available on areas likely to compromise patient safety.**"

Recommendation #2j: Establish a system for healthcare organizations to report medical errors, "near misses" and solutions to patient safety problems.

Several Commissioners had objections to the wording of this recommendation. Generally Commissioners were concerned about inadvertently suggesting that reporting was required. Various options were discussed. It was agreed #2j would be **renumbered as discussed above**, and revised as follows: "**Establish a process to allow healthcare organizations and practitioners to report adverse events, near-misses and/or solutions to patient safety problems.**"

Recommendation #2k: Work with the General Assembly to determine whether future data reporting should be a mandatory or voluntary effort.

Several Commissioners were concerned that this recommendation could be taken too far. Dr. Jantsch mentioned that she received many negative responses to this recommendation from colleagues. Various options were discussed for making it clearer that the Commission was recommending further study on the question of mandatory vs. voluntary reporting, as opposed to recommending new laws on reporting. These ideas didn't generate satisfaction. Scott Lakin suggested the "Center" should report periodically to the Missouri General Assembly on patient safety issues. In light of term limits, there will always be a need for educating legislators on safety issues. The Commissioners liked this idea. It was agreed to re-write #2k as follows: "**The Center should report periodically to the Missouri general assembly, and educate new members regarding patient safety issues.**"

Recommendation #3: Create a secure environment for safety analysis and improvements and peer review activities in order to encourage healthcare professionals and healthcare organizations to develop internal review procedures and to participate in improvement activities, which will lead to increased patient safety.

Dr. Utley felt the recommendation was too wordy. Tom Cartmell felt it wasn't clear. The recommendation should clearly state that a change in the law is needed. Kathryn agreed the recommendation wasn't clear, particularly regarding what is protected. Dr. Laiben suggested using the alternative language, with some changes. It was agreed to revise #3 as follows: "**Review current statutory provisions for peer review activities and recommend changes to provide for better protection of quality assurance, improvement and patient safety activities, thereby encouraging healthcare professionals to voluntarily report information and to participate in peer review/quality improvement activities that will lead to increased patient safety.**"

Recommendation #3a: Provide for unrestricted healthcare organization peer review committee membership.

Ken Vuylsteke felt "unrestricted" was not acceptable, and suggested, "expanded". In fact, some of his colleagues will feel "expanded" is asking too much. Kathryn Nelson was concerned that hospitals would read "peer review" as separate from "systems analysis" and try to put maintenance workers on peer review committees, where they don't belong. The legal protection afforded to the peer review process should be expanded to include the systems analysis process, and membership on systems analysis committees should be unrestricted. Dr. Utley agreed. Tom Cartmell felt that testimony from Children's Mercy Hospital spoke to open membership on peer review, because the courts have already expanded peer review beyond just doctors to include incidents.

Ken Vuylsteke again countered that any expansion to the right to withhold information from plaintiffs' attorneys would be vigorously fought. The recommendation should be as limited and specific as possible.

Kathryn Nelson suggested **moving #3a down, and putting #3d first in the list of sub-points.** This would emphasize the main goal of protecting patient safety discussions from exposure in a medical malpractice case. The idea of broadening membership on specifically peer review committees follows as a corollary to protection for patient safety committees. **This was agreeable to all.**

Tom Cartmell suggested language that people could agree to. It was agreed to revise #3a as follows: "**Expand the definition of peer review committee in the current statute to include non-healthcare providers and additional healthcare providers that are not currently listed.**"

Recommendation #3b: Eliminate cumbersome process and requirements for appointing healthcare organization peer review committees.

Dr. Laiben noted that **"process" should be plural.** Other than that there were no comments or suggestions for changes.

Recommendation #3c: Expand the scope of protected (privileged) activities intended to improve the quality of healthcare and improve patient safety.

Dr. Laiben supported full inclusion of the optional language currently in parentheses. No on disagreed.

Kathryn Nelson asked how #3c differs from #3d. Dr. Laiben pointed out that #3d specifically gets to sharing information between healthcare organizations. However, after much discussion it was felt that #3d encompassed the goal of #3c. **It was agreed to eliminate #3c.**

Recommendation #3d: Extend peer review protections to healthcare organization committees that evaluate healthcare delivery processes and systems and share that information between healthcare organizations.

It was agreed that, if #3d was meant to encompass #3c, then the concept of sharing data between organizations, and protecting that, should be treated separately from the concept of protecting patient safety discussions within a single organization.

Tom Cartmell suggested adding several additional terms in order to capture quality improvement activities beyond patient safety. Kathryn Nelson agreed.

Reflecting subsequent discussion, it was agreed to revise #3d as follows: "**Extend protections to healthcare organization committees <u>that are created solely</u> to <u>investigate</u>, evaluate <u>and improve patient safety and</u> healthcare delivery processes and systems.**"

A new sub-point, mirroring the revised language of #3d, would address the issue of sharing patient safety information between providers.

Dr. Laiben pointed out that "extend" would not be the right word to use, since no protection for this activity currently exists. Tom Cartmell suggested, "create" instead of "extend".

Ken Vuylsteke felt this language was too broad. It should be clear that you couldn't design information to protect providers from legitimate accountability for malpractice. He felt the potential to abuse the protection would cause consumer advocates to fight the recommendation. Accountability should be side by side with expanded protection. Tom Cartmell stated that he didn't think new protection

would truly prevent proof of malpractice from coming to light. Kathryn Nelson noted that the Institute of Medicine report makes a similar recommendation and specifies the protection applies solely to patient safety activities. Ken Vuylsteke agreed that adding "solely" would help.

The sub-point should read: "**Create protection for information shared between healthcare organizations which is designed solely for improving patient safety and healthcare delivery processes and systems.**"

Recommendation #3e: Patient safety data, documents or information reported to the "Patient Safety Support Center" for the purpose of improving the quality of healthcare shall be protected from use in civil, judicial or administrative procedures.

There were no comments or suggestions for changes on this item.

Recommendation #3f: Evaluate existing disincentives for error reporting and make recommendations to change those disincentives if appropriate.

Dr. Laiben asked to replace "if" with "as". As discussed earlier, "error" will be replaced. In this case, "adverse event" should be used, but not "adverse outcome".

Kathryn Nelson asked if there should be a sub-point on disclosure to patients. Ken Vuylsteke felt there should be. Various options were discussed. **It was agreed that Ken would draft an addition to #3f to the effect of weighing the needs of patients against any proposed changes.**

Recommendation #3g: (alternate language agreed to earlier) Establish **protections preventing adverse employment actions being taken against healthcare professionals or employees reporting unsafe healthcare conditions or incidences of healthcare error.**

There were no additional comments or suggestions for changes to this item.

Recommendation #4: Improve education of and communication among healthcare professionals and healthcare organizations (as it relates to patient safety activities and ideas).

Susan Kendig had previously emailed to all Commissioners some alternative language for this recommendation. Everyone read the alternative and agreed to it. The recommendation will read: "**Improve education opportunities for current and future healthcare professionals as it relates to patient safety concepts.**"

Recommendation #4a: Work with agencies responsible for setting healthcare professional's education requirements, (such as the ACGME (?), to strengthen healthcare professional educational curricula through incorporation of key patient

safety concepts, such as communication skills, system failure analysis, risk management, and other proven risk-reducing factors.

Susan Kendig had previously emailed to all Commissioners some alternative language for this recommendation. Everyone read the alternative and agreed to it. The recommendation will read: "**Work with accreditation agencies responsible for establishing healthcare professionals' education requirements to strengthen healthcare professional educational curriculum through incorporation of key patient safety concepts.**"

Recommendation #4b: Promote ways to increase communication among healthcare professionals at all levels of healthcare delivery.

Susan Kendig had previously emailed to all Commissioners some alternative language for this recommendation. Dr. Laiben asked to emphasize that communication will be improved as opposed to increased. The Commissioners agreed to the revisions. The recommendation will read: "**Promote ways to improve communication among healthcare professionals at all levels of healthcare delivery.**"

Susan Kendig's proposed changes would result in this recommendation moving up and becoming #4a, and #4a becoming #4b. The Commissioners agreed to this.

Recommendation #4c: Assure healthcare professional competency in patient safety through patient safety related Continuing Medical Education (CME) activities.

Susan Kendig had previously emailed to all Commissioners some alternative language for this recommendation. Everyone read the alternative and agreed to it. The recommendation will read: "**Assure competency in patient safety through patient safety related continuing education activities.**"

Recommendation #5: The legislators, elected officials, associations representing healthcare professionals and healthcare organizations, and regulatory agencies should work together in the interest of patient safety, to evaluate and address regulatory issues (negatively impacting patient safety activities proven to be effective).

Dr. Laiben preferred the alternative language presented in the draft. Kathryn Nelson agreed. The Commissioners concurred. Dr. Laiben also felt the recommendation read awkwardly and suggested a minor edit. The Commissioners agreed. The recommendation will read: "**The legislators, elected officials, <u>professional</u> healthcare associations and regulatory agencies need to work together to evaluate and address the issues associated with effective regulation in the interest of patient safety.**"

Recommendation #5a: Health professional licensing bodies should work with certifying and credentialing organizations to develop more effective methods to identify unsafe providers and take action.

Kathryn Nelson asked if it was necessary to note that the Institute of Medicine "To Err is Human" report was the source for this recommendation. **Linda Bohrer suggested that it could be footnoted.** The Commissioners agreed to this. There were no other comments or suggestions for changes.

Recommendation #6: Enhance patient involvement in healthcare with the goal of improving patient understanding of medical conditions and procedures, (and) improving communication between patients and healthcare professionals (and improving safety within healthcare organization).

Susan Kendig had previously emailed to all Commissioners some alternative language for this recommendation. Everyone read the alternative and agreed to it; with the exception that "provider" should be "professional". The recommendation will read: "**Recognize the patient as a central member of the healthcare team through development of strategies to enhance communication between patients and healthcare professionals; and, improve patient understanding of health conditions and medical procedures.**"

Recommendation #6a: The patient should become a member of the healthcare team by educating themselves on their healthcare condition and treatment choices and communicating with their healthcare professional.

Kathryn Nelson was concerned that the recommendation made it sound like it was the patient's fault for not accomplishing his or her own self-education. Many things are simply not said to the patient, and the patient has no power to get that information if the provider doesn't volunteer it. Providers don't make it easy to navigate the healthcare system. Susan Kendig had previously emailed to all Commissioners some alternative language for this recommendation. Everyone read the alternative and agreed to it. The recommendation will read: "**The patient should have access to information and materials that support their ability to educate themselves on their health conditions, treatment options, and navigating the healthcare system.**"

Recommendation #6b: Through education of both consumers and healthcare professional, support the patient's central role in the healthcare team.

Susan Kendig had previously emailed to all Commissioners some alternative language for this recommendation. Everyone read the alternative and agreed to it. The recommendation will read: "**Education of both consumers and healthcare professionals will target enhanced communication and support the patient's central role in the healthcare team.**"

Recommendation #6c: The patient should become familiar with the "patient safety officer" or patient advocate and their role in the healthcare organizations with which they do business.

Kathryn Nelson felt it was too much to expect the patient to chase this person down. The facility should make sure the patient knows whom this person is. Dr. Laiben felt this sub-point was acceptable, but suggested putting something under recommendation #1 that would correlate to recommendation #6, emphasizing both the provider's and the patient's role. Linda Bohrer pointed out that #1b is to be redrafted to capture essentially this concept.

Kathryn Nelson suggested that "patient safety officer" was not the appropriate person for the patient to go to. William Schoenhard agreed. Randy McConnell suggested an edit that would make the sentence more active. It was agreed that #6c would be revised as follows: "**The patient should have access to the patient advocate and their role in the healthcare organizations with which they do business.**"

Recommendation #6d: Consumers and healthcare professionals should support efforts to make patient safety education materials available to all Missourians.

There were no comments or suggestions for changes.

Recommendation #6e: Consumers and healthcare professionals should encourage the development of useful and innovative patient education materials (like the Graphic Surgery program).

Kathryn Nelson did not feel it was appropriate to name a specific private company. Dr. Laiben agreed. The company should be mentioned in the text of the report. It was agreed #6e would be revised as follows: "**Consumers and healthcare professionals should encourage the development of useful and innovative patient education materials.**"

Recommendation #6f: Maintain consumer healthcare advocacy and healthcare complaint investigation systems in state agencies and organizations and continue the state's active responsiveness to those consumer concerns.

There were no comments or suggestions for changes.

Recommendation #6g: Conduct research to gain a better understanding of consumers' views and beliefs about their safety as patients. This could be done through the "Patient Safety Support Center".

Dr. Laiben suggested leaving out the second sentence. Kathryn Nelson agreed. Randy McConnell asked about the sentence structure, pointing out that the patients would not be doing the research. Dr. Laiben suggested putting it under the

recommendations for the "Center", under the educational portion. Everyone agreed to this. The recommendation will be **relocated to #2** and will read: "**Conduct research to gain a better understanding of consumers' views and beliefs about their safety as patients.**"

Recommendation #6h: Share publicly available patient safety data and disseminate consumer safety alerts. Availability of this information can be handled by the "Patient Safety Support Center".

Dr. Laiben suggested this recommendation should also be moved to #2. This would make the second sentence unnecessary again. Everyone agreed. The recommendation will be relocated to #2 and will read: "**Share publicly available patient safety data and disseminate consumer safety alerts.**"

Recommendation #7: Patient safety activities should be encouraged whenever possible, when contracting with healthcare professionals and healthcare organizations.

Dr. Utley provided alternative language. Dr. Laiben noted that some constituents are concerned that requiring patient safety activities through contracting will decrease access to providers, especially in the Medicaid program. Dr. Jantsch felt that nothing in the statement explicitly required patient safety activities, but implied that preferential treatment would be extended to those that engage in patient safety activities.

Will Schoenhard felt the alternate language more clearly expressed the many different directions this recommendation was intended to take. Others agreed. Dr. Laiben asked to remove the parenthetical marks. Kathryn Nelson suggested using "healthcare" just once. It was agreed that #7 would be revised as follows: "**Any person, organization or agency, working with healthcare professionals and/or organizations, should encourage, with incentives, healthcare professionals and/or healthcare organizations to participate in established and proven patient safety activities.**"

Recommendation #7a: Healthcare professionals and healthcare organizations and their member organizations should work with insurers, including the new Missouri Medical Malpractice Joint Underwriting Association board of directors, to provide medical liability discounts for healthcare professionals and healthcare organizations that proactively participate in proven patient safety activities.

There were no comments or suggestions for changes.

Recommendation #7b: Missouri should include contracting provisions that contain patient safety incentives (or requirements) in any contract the state enters into that results in payment for healthcare services (an example of which would be the

contracts signed in their role as a purchaser of healthcare plans through Missouri Consolidated Health Care Plan and the state Medicaid program).

Dr. Jantsch felt this recommendation read too much like hard requirements to get a contract. Dr. Laiben and Kathryn Nelson agreed. The text should be clear that safety incentives should be offered, but contracting disincentives will not be the result of implementing the recommendation. Dr. Laiben suggested removing everything inside parentheses marks.

Dr. Jantsch and William Schoenhard expressed concern that the recommendation might result in unfunded requirements placed on providers. If the State provided additional payment to a contractor, there was no guarantee the contractor would provide additional payment to healthcare professionals and facilities. Dr. Laiben had mentioned previously that "Missouri" should be replaced with "Payers and responsible parties". It was agreed #7b would be revised as follows: "**Payers and responsible parties should be encouraged to include contracting provisions that contain patient safety incentives in any contract they enter into that results in payment for healthcare services.**"

III. CLOSING REMARKS AND DISCUSSION OF FUTURE MEETINGS

Dr. Laiben asked Kathryn Nelson to provide assistance so that they could together take a look at the order of the sub-points under each main recommendation.

With regard to the glossary of terms, Dr. Laiben was glad that source information had been provided. However, he felt there was much to discuss. Linda Bohrer noted that William Schoenhard and the Hospital Association asked to incorporate their definition of "ambulatory surgical center" into the definition of "healthcare organization". Kathryn Nelson agreed. Dr. Laiben suggested that he and Kathryn Nelson work on revisions to this document.

It was agreed that, depending on the nature and volume of comments from other Commissioners, Dr. Laiben and Kathryn Nelson would determine later if an additional conference call was needed before the June 17 call.

Linda Bohrer will email revised documents to all Commissioners by 5 PM on May 28 (Friday). **Linda should receive any additional comments or edits Commissioners wish to send no later than 5 PM on June 1 (Tuesday). Commissioners are asked to use the "Reply to all" feature.**

The call was concluded at 2:30 PM.